

Racism and mental health

The COVID-19 pandemic, with its striking inequities in mortality rates between Whites and stigmatized racial/ethnic groups in the US and UK, and the recent global protests about police violence have raised questions about and increased interest in the potential impacts of racism on health and particularly on mental health.

Racism is an organized societal system in which the dominant White group categorizes individuals into “races” and devalues, disempowers, and differentially allocates resources to ethnic groups considered to be inferior¹. The ideology of inferiority permeates societal systems and institutions ensuring that racism is not limited to individual beliefs and behaviors¹. Racism operates through institutional, interpersonal and cultural pathways. Here we provide a brief overview of these levels of racism and how they can adversely affect mental health.

Institutional or structural racism can be defined as racial discrimination that is embedded in institutional structures and policies¹. Examples of institutional racism include residential segregation, racialized immigration policy, and racialized incarceration. For example, in the US, residential segregation, the physical separation of races by enforced residence in particular places, is a central determinant of racial inequities in health. Residing in areas with concentrated poverty and social disadvantage can adversely affect mental health by leading to high levels of exposure to stressors (psychosocial, physical and chemical) and reduced access to opportunities and resources, including schooling, employment, and health services. Empirical analyses reveal that eliminating residential segregation in the US would erase racial differences in income, education and unemployment, and reduce racial differences in single motherhood by two thirds¹.

Immigration policies often reproduce ideologies of belonging and othering that are patterned by race/ethnicity and can adversely affect racialized immigrant groups. Research documents that exclusionary immigration policies with restrictions on rights and aggressive anti-immigrant policy enforcement have negative effects on mental health².

Racialized incarceration also has mental health consequences. The US have the largest incarcerated population globally, with an overrepresentation of Blacks and Latinos³. This has facilitated a historic shift from mental illness being treated in hospitals to being treated in carceral systems, which has led to jails and prisons in the US becoming the largest providers of mental health care. A national study in the US found that prior arrest history was associated with the prevalence of major depressive disorder among African Americans and Caribbean Blacks⁴. In addition, other US research reveals that aggressive policing, such as the killing of unarmed African Americans, leads to declining mental health for the entire Black population in the state in which the incident occurs¹.

Self-reported interpersonal discrimination is the most studied domain of racism in the mental health literature. A review of literature reviews and meta-analyses published between 2013

and 2019 on discrimination and health identified eight reviews focused on mental health⁵. Although most studies came from the US, there were studies from some 20 countries. This body of research indicates that discrimination was positively associated with increased risk of major mental disorders and inversely related to positive mental health outcomes such as life satisfaction and self-esteem. The accumulation of experiences of discrimination over time was associated with increasing risk of mental health problems. Exposure to discrimination was also associated with adverse changes in personality over time, such as increases in neuroticism.

Although the majority of studies have been cross-sectional, a growing number of prospective studies link discrimination to mental health risk. Some studies have also documented that the association between discrimination and mental health is robust to adjustment for potential psychological confounders such as neuroticism⁶. In addition, racial discrimination is also linked to worse mental health and increase in risky behavior for children and adolescents⁷. In addition to direct exposure to racial discrimination, vicarious exposure, through parental or caregiver experiences of discrimination, is also associated with worse mental health outcomes⁸.

Cultural racism refers to the racist ideologies that are present in the media, stereotypes, and norms of society that undergird institutional and interpersonal racism¹. It can affect mental health in multiple ways. First, cultural racism can initiate and sustain policies that create conditions which are harmful to mental health, such as housing decisions to maintain residential segregation which facilitates increased exposure to traumatic experiences and a broad range of physical and social stressors. Second, some members of stigmatized racial groups internalize the negative racial stereotypes of the culture, which in turn can lead to increased psychological distress and substance use. Third, cultural racism can also trigger stereotype threat – expectations and anxieties activated by a stigmatized group when negative stereotypes about their group are made salient. Research reveals that stereotype threat can lead to increased anxiety, reduced self-regulation, and impaired decision making, which can also affect patient-provider communication and adherence to medical advice¹.

Furthermore, cultural racism can lead to individual-level unconscious bias in clinicians that can trigger discrimination adversely affecting the quality of clinical care. For example, research has documented racial differences in the application of psychiatric diagnostic criteria, so that Latinos are diagnosed with anxiety disorders more frequently than White people reporting the same symptoms⁴. Similarly, clinicians exposed to the same symptoms are more likely to diagnose African Americans with psychotic disorders than mood disorders compared to Whites⁴.

Future research is needed to better understand the intersection of racial discrimination with other forms of group discrimination (e.g., gender-related) and identify how multiple forms of discrimination may impact mental health. Emerging evidence

indicates that multiple forms of discrimination, such as racism and heterosexism, are associated with increased risk of mental health problems⁹. Additionally, our current understanding is limited about the potential intergenerational impacts of racism and their related epigenetic effects, with emerging evidence suggesting that these processes are likely to be operative¹.

Research on racism and mental health, to date, has focused more on documenting that racism matters than on identifying interventions to minimize the adverse effects of exposure to racism and reduce the occurrence of racism in the first place. Some evidence suggests that psychosocial resources such as social ties and religious involvement can reduce some of the negative effects of discrimination on mental health⁶. However, effectively addressing the multifactorial impacts of racism on mental health will require multilevel societal interventions that seek to build racial equity into homes, schools, neighborhoods and workplaces to minimize current racial economic gaps and improve socioeconomic and living conditions for the disadvantaged.

Interventions around resiliency and cultural/structural competency in the medical field have shown some promise, but more concerted attention is needed to address the multiple and interconnected systems through which racism operates^{1,3}. Diversifying the mental health workforce in terms of including

underrepresented racial/ethnic groups and professional experience (e.g., medicine, social work, religion) is also a necessary step towards addressing inequities in mental health care³. Comprehensive, coordinated, strategic initiatives are needed both within and outside of psychiatry and medicine to better understand, prevent and effectively intervene on the effects of racism on mental health.

David R. Williams^{1,2}, Onisha S. Etkins¹

¹Department of Social and Behavioral Sciences, Harvard T.H. Chan School of Public Health, Boston, MA, USA; ²Department of African and African American Studies, Harvard University, Cambridge, MA, USA

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The epidemic of fentanyl misuse and overdoses: challenges and strategies

Fentanyl, a synthetic opioid with analgesic and anesthetic properties, is currently associated with one of the deadliest addiction crises in the US. Misuse of fentanyl (and fentanyl analogues) has been estimated to be responsible for 48,000 (out of a total of 83,335) overdose deaths in the 12 months ending in June 2020¹, a rate that has increased more than 29 fold since 2012, when the annual fatalities from fentanyl and its analogues were 1,615.

The cases of overdoses and deaths in the US are linked to illegally manufactured fentanyl, which rapidly penetrated the US illicit market since 2013. Though not as pervasively as in the US, increases in overdose deaths due to illicit fentanyl and its analogues have also occurred in Canada, in several European countries (including Estonia, Germany, Finland and the UK) and in Australia².

Fentanyl is relatively easy to synthesize and manufacture, and less difficult to traffic than heroin, since it requires much smaller volumes to transport across borders. It is, therefore, hugely profitable to drug dealers (50-100 times more than heroin), which can be expected to result in an expansion of the illicit fentanyl market across the globe.

The majority of opioid-related overdose deaths in the US are the result of fentanyl being ingested as a substitute for heroin or with drugs such as cocaine and methamphetamine that had been adulterated (cut) with the opioid, frequently without users

being aware of this. Fentanyl, when used by itself or in combination with other drugs, can be taken orally, injected, snorted or smoked. Most heroin users do not report actively seeking fentanyl, and some are afraid of it but might have no choice because of the higher costs of uncontaminated heroin or its unavailability.

When fentanyl is used to adulterate other drugs (heroin, prescription opioids, psychostimulants), it increases their lethality. In the case of psychostimulants, this occurs not only due to the synergistic effects on the cardiopulmonary system, but also because stimulant users, who have no tolerance to opioids, are at very high risk of overdosing when ingesting fentanyl.

The unique pharmacological effects of fentanyl have contributed to its widespread misuse and are also the ones that make it a valuable therapeutic for anesthesia and for severe pain management. Fentanyl binds to mu-opioid receptors (MOR), which mediate the analgesic and the rewarding effects of opioid drugs, such as morphine and heroin, as well as their respiratory depressing actions³. However, fentanyl is much more potent at activating MOR-associated signaling than morphine (80-100 fold) or heroin (30-50 fold), and its higher lipophilicity leads to higher and faster brain uptake than for those other drugs. These properties underlie fentanyl's high potency as an analgesic and its rapid actions, which are beneficial for the treatment of breakthrough pain or other severe pain conditions. However, they are also responsible for its powerful rewarding effects, which can rapidly